INDEPENDENT RURAL HEALTH CLINIC PROGRAM

(1) Authority. This is the payment methodology used to reimburse providers in the Medicaid Independent Rural Health Clinic Program.

(2) Qualifications. For a clinic to qualify for participation in the Medicaid Independent Rural Health Clinic program, the clinic must meet the following criteria:

(A) Must be an independent facility, which means that the clinic may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital.

(3) General Principles.

(A) The Missouri Medical Assistance (Medicaid) program shall reimburse Independent Rural Health Clinic (RHC) providers based on the reasonable cost of RHC-covered services related to the care of Medicaid recipients (within program limitations) less any copayment or other third party liability amounts which may be due from Medicaid recipients.

(B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.

(4) Definitions. The following definitions shall apply for the purpose of this regulation.

(A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(C) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period.

(D) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(E) Medicaid cost report. The documents used, for the purpose of reporting the cost of rendering both covered and non-covered services for the facility's fiscal year, shall be the Medicare cost report forms [HCFA-222 (3/83)] and all worksheets supplied by the division.

(F) Provider or facility. An Independent Rural Health Clinic with a valid Medicaid participation agreement in effect with the Department of Social Services for the purpose of providing RHC services to Title XIX-eligible recipients.

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each Independent RHC shall complete a Medicaid cost report for the RHC's twelve (12)-month fiscal period.

2. Each RHC is required to complete and submit to the Division of Medical Services an Annual Cost Report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this regulation.

4. The cost report shall be submitted within three (3) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days, may be granted upon the request of the RHC and the approval of the Missouri Division of Medical Services. The request must be received in writing by the division prior to the ninetieth day of the three (3) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within three (3) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the last five (5) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts and income from endowments, including: amounts, restrictions, and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases and/or rental agreements related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstances will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand.

D. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the recordkeeping requirements of 42 CFR 413.20.

E. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the RHC does not maintain records that provide an adequate basis to determine payments under Medicaid.

B. The suspension or reduction continues until the RHC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(C) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

(D) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the Medicaid program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(6) Nonallowable Costs. Cost not reasonably related to RHC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Grants, gifts and income from endowments will be deducted from total operating costs;

(B) Bad debts, charity and courtesy allowances;

(C) Return on equity capital;

(D) Capital cost increases due solely to changes in ownership;

(E) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(F) Attorney fees related to litigation involving state, local or federal governmental entities and attorney's fees which are not related to the provision of RHC services, such as litigation related to disputes between or among owners, operators or administrators;

(G) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(H) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on intangible assets;

(M) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(N) Research costs;

(O) Salaries, wages or fees paid to nonworking officers, employees or consultants;

(P) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(Q) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing RHC services to Title XIX-eligible recipients.

(7) Interim Payments. Independent RHC's, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid at the Medicare RHC rate. Interim payments shall be reduced by copayments and other third party liabilities.

(8) Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each RHC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the RHC's net reimbursement shall equal reasonable costs as described within this section.

(1) The total reimbursement amount due the RHC for covered services furnished to Medicaid recipients is based on the Medicaid cost report and is calculated as follows:

(a) The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC services furnished during the period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this regulation or incorporated in the Allowable Cost per visit as determined on Worksheet 3.A., line 7.

(b) The total cost of RHC services furnished to Medicaid recipients is calculated by multiplying the allowable cost per visit by the number of Medicaid visits for covered RHC services.

(2) The total reimbursable cost is compared with total payments and third party liability made to the RHC for the reporting period.

(3) The total reimbursement will be subject to adjustment based on the results of a field audit which may be conducted by the Division of Medical Services or its contracted agents.

(B) Notice of program reimbursement. The division shall send written notice to the RHC of the following:

1. Underpayments. If the total reimbursement due the RHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the RHC to bring total interim payments into agreement with total reimbursement due the RHC.

2. Overpayments. If the total interim payments made to a RHC for the reporting period exceed the total reimbursement due the RHC for the period, the division arranges with the RHC for repayment through a lump-sum refund, or through offset against subsequent interim payments or a combination of offset and refund.

(C) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

(9) Sanctions.

(A) The division may impose sanctions against a provider for false or fraudulent claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division for false or fraudulent claims for Title XIX Services.

(10) Appeals. Providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(11) Payment Assurance.

(A) The state will pay each RHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the RHC according to the standards and methods set forth in the regulations implementing the RHC Reimbursement Program.

(B) RHC services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any RHC previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the FQHC's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(12) Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable copayments.